

Guidelines for Physician Assistant License Application

Carefully read all of the items on the enclosed application for licensure. Your completed application will require a number of additional documents.

- Application for physician assistant license with three parts:
 1. General applicant information
 2. If applicable, work-setting information. Your license may be issued without this information, but you must have it on file before any practice begins.
 3. A notarized affidavit (application Page 5)
- NCCPA documentation of certification is required. Send a copy of the enclosed form (on application Page 6) to NCCPA to request this documentation. Submit a copy of the completed form with your application.
- Official Transcripts, in institutionally sealed envelopes, from undergraduate **and** Physician Assistant schools. It is not necessary to submit additional transcripts if they are already on file with the Board as part of your application for a Temporary Practice Certificate.
- The Board accepts an official Physician Assistant Information Profile from the Federation of State Medical Boards' **Federation Credentials Verification Service** in lieu of transcripts and NCCPA documentation. For more information about the FCVS Profile, visit the FSMB web site, at <http://www.fsmb.org>.
- A verification of licensure status, in an institutionally sealed envelope, from any jurisdiction where you have ever held *any* professional license.
- A check or money order payable to "Commonwealth of Massachusetts" for \$151.00

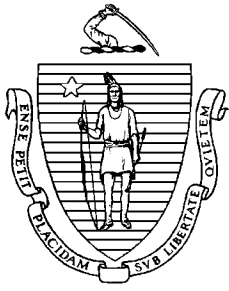
The answers to most of your questions about licensure will be found in the regulations. If you have questions *after* reviewing the regulations, you may contact the Board office at (617) 727-4499.

Physician Assistant licensure requirements are found in the Massachusetts General Laws, Chapter 112, sections 9C - 9K. The General Laws are available in most libraries or online at <http://www.state.ma.us/legis/laws/mgl/index.htm>.

The Board of Registration of Physician Assistant regulations, at 263 Code of Massachusetts Regulations (CMR) 2.00 - 6.00, governing physician assistants licensure and practice, are available on the Board's web site, at <http://www.state.ma.us/reg/boards/ap>. The regulations may also be purchased from the State House Bookstore for a nominal fee.

State House, Room 116
Boston MA 02108
(617) 727-2834

Processing time varies considerably, depending on the background of the applicant. Typically, from the time a fully completed application is received, **you can expect notification of your status in 2-4 weeks**. If you have a valid Massachusetts Physician Assistant Temporary Practice Certificate, the Certificate remains valid until your license application is processed.



Commonwealth of Massachusetts
Division of Professional Licensure
Board of Registration of Physician Assistants
239 Causeway Street
Boston MA 02114
(617) 727-3069

<http://www.state.ma.us/reg/boards/ap>

License Application - \$151.00

1a. Applicant Name: _____
LAST FIRST MIDDLE

1b. Previous name: _____
LAST FIRST MIDDLE

2. Address: _____
NO. STREET APT. #
CITY/TOWN STATE ZIP+4 CODE

3. Telephone Number(s) Day: _____ Evening: _____
Email (optional) _____

4. Date of Birth: ____/____/____
(mm/dd/yyyy)

5. Gender: M F
(Circle One)

6. Social Security Number: _____

(Disclosure is mandatory) Pursuant to G.L. c. 62C, s. 47A, the Division of Registration is required to obtain your social security number and forward it to the Department of Revenue. The Department of Revenue will use your social security number to ascertain whether you are in compliance with the tax laws of the Commonwealth.

7. NCCPA Certificate No. _____ Expiration ____/____/____
(mm/yyyy)

Date of Last Examination: _____
(mm/yyyy)

Arrange for official documentation of certification to be sent to the Board directly from NCCPA. See application Page 6. Not required if you are submitting a Physician Assistant Information Profile from the Federation of State Medical Board's Credentials Verification Service.

FOR BOARD USE ONLY:

Cash Number: _____ License Number: _____
Temp. Certificate Number: _____

8. Education Submit official transcript in institution-sealed envelope IF NOT ALREADY SUBMITTED TO THE BOARD WITH APPLICATION FOR A TEMPORARY PRACTICE PERMIT. Not required if you are submitting a Physician Assistant Information Profile from the Federation of State Medical Board's Credentials Verification Service.

PA Program Name/Location: _____

Degree awarded: _____ Date of Graduation: _____
 ____/____ (mm/yyyy)

Name and location of Institution Granting Bachelors Degree: _____

Degree: _____ Date Awarded: ____/____
 (mm/yyyy)

Name and location of other post-secondary educational institution :

Degree: _____ Date Awarded: ____/____
 (mm/yyyy)

9. List all employment as a Physician Assistant with current employment first:

Name of Facility or Physician	Address	Dates

10. List any professional licenses or certifications held in any jurisdiction.
 (Attach an unopened certificate of standing from each jurisdiction)

Lic. No. Issuing Jurisdiction

11. WORK SETTING INFORMATION

Complete A Separate Copy Of This Section For Each Work Setting

If not currently employed as a Physician Assistant, retain a copy of this page, and submit the information when available. A copy must be on file in the Board office before you begin employment.

Applicant: _____
LAST FIRST MIDDLE LIC. NO.
(if any)

Name of Facility or Office: _____

Address: _____

Type Facility: Office () Clinic () HMO () Hospital () Other: _____

Type Employment: Full time () Part time ()

List names of Massachusetts hospitals at which you practice or are affiliated within this work setting:

Check all areas of practice that apply to this setting:

___ Primary Care	___ Administration	___ Emergency Medicine
___ General Surgery	___ Internal medicine	___ Occupational health
___ Geriatric medicine	___ Education	___ Pediatrics/Adolescents
___ Clinical research	___ Obstetrics/Gyn.	
___ Other (specify) _____		

12. SUPERVISING PHYSICIAN INFORMATION

Complete A Separate Copy For Each Supervisor

Applicant: _____
LAST FIRST MIDDLE LIC. NO.
(if any)

Physician: _____
LAST FIRST MIDDLE LIC. NO.

TO BE COMPLETED BY SUPERVISING PHYSICIAN:

A licensed physician can be the Supervising Physician of Record for no more than two (2) Physician Assistants at any one time [M.G.L., C 112 §9E and 263 CMR 5.05 (2)] Physician Assistants supervised in past two years:

Name: _____	Dates: _____
Name: _____	Dates: _____
Name: _____	Dates: _____
Name: _____	Dates: _____

Have you (the Supervising Physician) been disciplined (as defined by the Board of Registration in Medicine regulations) by any government authority, hospital or other health care facility, or professional medical association (international, national or local) within the last ten (10) years from the date of this application? ☐ Yes ☐ No

Within the last ten (10) years from the date of this application, have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action or has any quality assurance committee suggested any form of corrective action concerning your practice. ☐ Yes ☐ No

I understand that, notwithstanding any other provisions of law, a physician assistant may perform medical services when such services are rendered under my supervision. Such supervision shall be continuous, but shall not require my personal presence. **I will supervise no more than two physician assistants at any one time.**

Signature of Supervising Physician

Date

The following **applicant** questions require an attached, detailed explanation for any YES answer.

13. Have you ever been a defendant in a Medical Malpractice claim? Yes ☐ No ☐
Include claim #, date and current status of claim with your explanation.
14. Have you ever applied for and been denied a professional license in the United States or any country or foreign jurisdiction?
Yes ☐ No ☐
15. Has any disciplinary action been taken against you by a licensing/certification board located in the United States or any country or foreign jurisdiction?
Yes ☐ No ☐
16. Are you the subject of pending disciplinary actions by a licensing/certification board located in the United States or any country or foreign jurisdiction?
Yes ☐ No ☐
17. Have you voluntarily surrendered a professional license to a licensing/certification board in the United States or any country or foreign jurisdiction?
Yes ☐ No ☐
18. Have you ever been convicted of a felony or misdemeanor in the United States or any country or foreign jurisdiction, other than a traffic violation for which a fine of less than \$100.00 was assessed?
Yes ☐ No ☐

AFFIDAVIT

I certify, under the pains and penalties of perjury, that the information I have provided pursuant to this application for licensure is truthful and accurate. I understand that the failure to provide accurate information may be grounds for the Massachusetts Board of Registration of Physician Assistants to suspend or revoke a license issued to me in accordance with Massachusetts Law. I further attest that, pursuant to MGL c.119, s.51A, I will fulfill my obligations to report abuse and neglect of children; that I will otherwise conform to the ethical standards of the medical profession in Massachusetts and all rules and regulations of the Board; and that I have read and understand this affidavit.

To the best of my knowledge and belief, I have filed all state tax returns and paid all state taxes required by law.

Signature of Applicant

Date

Notary Name: _____

Commission expires: _____

Notary Signature_____

Attach a recent passport-type photograph here.

This form is not required if you are submitting a Physician Assistant Information Profile from the Federation of State Medical Board's Credentials Verification Service.

If you did not complete this form as part of your application for a MA Temporary Practice Certificate, photocopy this page, complete the form and mail it to

NCCPA
12000 Findley Road
Suite 200
Duluth, GA 30097

I hereby authorize and direct the National Commission on Certification of Physician Assistants, Inc., to release to the

Massachusetts Board of Registration of Physician Assistants
239 Causeway Street
Boston MA 02114

any and all information concerning my eligibility, examination, and/or certification status, and/or examination scores which the Massachusetts Board of Registration of Physician Assistants may require in conjunction with my application for registration. I hereby release the National Council on Certification of Physician Assistants, Inc., and its agents and employees from any liability arising out of its compliance with such a request for information.

Signature of Applicant

Date

1a. Applicant Name: _____
LAST FIRST MIDDLE

1b. Previous name: _____
LAST FIRST MIDDLE

2. Address: _____
NO. STREET APT. #

CITY/TOWN STATE ZIP+4 CODE

3. Day Telephone Number(s) : _____

4. Date of Birth: ____/____/____
(mm/dd/yyyy)

5. Social Security Number: _____

6. NCCPA Certificate No.: _____

7. Date of Exam: ____/____/____
(mm/dd/yyyy)